



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID W WIMBERLEY
7401 S MAIN STREET
HOUSTON TX 77030

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-1409-01

MFDR Date Received

February 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have reviewed the notes and feel that the documentation does support the level of service we are billing for."

Amount in Dispute: \$120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to meet the definition of code 99214 found in the 2012 CPT the documentation must meet 2 of the three required components... No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2012	99214	\$154.78	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-150 Payer deems the information submitted does not support this level of service.
 - CAC-16 Claim/service lacks information which is needed for adjudication at least one remark code must be provided (May be comprised of wither the remittance advice remark code or ncpdp reject reason code).
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 890– Denied per AMA CPT Code description for level of service and/or nature of presenting problems.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided..." Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is: "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."
 - Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Component met
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed five systems, this component was met.
 - Past Family, and/or Social History (PFSH) require at least one specific item from any three history areas to be documented. The documentation found listed three areas. This component was met.
 - Documentation of a Detailed Examination:
 - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed three body/organ systems: lumbar, neurologic musculoskeletal. This component was not met.

Counseling and/or coordination of care: The provider advised patient to return to activities as tolerated, MRI scan results were reviewed and the findings discussed in detail, referral to a pain management specialist was provided. Component not met.

The division concludes that the documentation does not sufficiently support the level of service billed.

2. For the reasons stated above, the services in dispute are not eligible for payment pursuant to 28 TAC §134.203 (c).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 16, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.